Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-361-2930

Streptococcus Group A, invasive disease

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed**
☐ **Probable**
By: ☐ **Lab** ☐ **Clinical**
☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Fever** Highest measured temp (^{o}F): ____ ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Current chickenpox (varicella) infection
☐	☐	☐	☐	Immunosuppressive therapy or disease
☐	☐	☐	☐	Neonatal Delivery location: _____
☐	☐	☐	☐	Postpartum mother (<= 6 weeks)
☐	☐	☐	☐	Preexisting injury, wound, or break in skin
☐	☐	☐	☐	Recent surgery

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	Meningitis
☐	☐	☐	☐	Bacteremia
☐	☐	☐	☐	Sepsis syndrome
☐	☐	☐	☐	Toxic shock syndrome
☐	☐	☐	☐	Septic arthritis
☐	☐	☐	☐	Cellulitis
☐	☐	☐	☐	Necrotizing fasciitis
☐	☐	☐	☐	Osteomyelitis
☐	☐	☐	☐	Pneumonia or pneumonitis X-ray confirmed ☐**Y** ☐**N** ☐**DK** ☐**NA**
☐	☐	☐	☐	Peritonitis
☐	☐	☐	☐	Gangrene
☐	☐	☐	☐	Other clinical syndrome Type: _____
☐	☐	☐	☐	Admitted to intensive care unit
☐	☐	☐	☐	Mechanical ventilation or intubation required during hospitalization

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy

Laboratory

Collection date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	***Streptococcus pyogenes*** **isolation by culture (normally sterile site: blood, CSF, joint, pleural, pericardial fluid, tissue specimen obtained during surgery, bronchial specimen)**

NOTES

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset:	***Exposure period***		onset	***Contagious period***
	-3	-1		Treated: 24 hours Untreated: weeks to months
Calendar dates:				

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____
_____
_____

Y N DK NA

☐ ☐ ☐ ☐ Contact with confirmed or presumptive case
☐ Household ☐ Sexual
☐ Needle use ☐ Other: _____

Y N DK NA

☐ ☐ ☐ ☐ Congregate living
☐ Barracks ☐ Corrections ☐ Long term care
☐ Dormitory ☐ Boarding school ☐ Camp
☐ Shelter ☐ Other: _____

☐ ☐ ☐ ☐ Work or volunteer in health care setting during exposure period
Facility name: _____

☐ ☐ ☐ ☐ Hospitalized during exposure period

☐ ☐ ☐ ☐ Injection street drug use, type: _____

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Nosocomial infection suspected

☐ ☐ ☐ ☐ Work or volunteer in health care setting during contagious period
Facility name: _____

☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Facility notified
☐ Facility inspection
☐ Other, specify: _____

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____